An Assessment of Hawaii QUEST Medical Plans Performance Using Medicaid HEDIS Measures, 1996-1997

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MEDICAID HEDIS Quality of Care Performance Measurements

What is Medicaid HEDIS?

HEDIS (Health Plan Employer Data and Information Set) is the performance measurement system for health plans developed by the National Committee for Quality Assurance (NCQA). The NCQA is an organization which accredits health plans as well as other types of health care organizations. The number of NCQA accredited managed care plans now exceeds 330, covering three quarters of all HMO enrollees or roughly 45 million Americans. HEDIS data is collected by more than 90 percent of all health plans. *Medicaid HEDIS* is an adaptation of *HEDIS 2.0/2.5* for use by health plans with Medicaid managed care programs. In 1997, *Medicaid HEDIS* was incorporated into *HEDIS 3.0.* Therefore, QUEST plans will report their HEDIS data for the 1998 fiscal year in *HEDIS* 3.0 format.

What is measured in Medicaid HEDIS?

Health plan performance related to the following seven (7) areas is measured:

- Membership;
- Utilization;
- Quality of Care;
- Access to Care;
- General Plan Management;
- Financial Performance; and
- Satisfaction with Care.

Health plan performance for membership, utilization, quality of care, and access measures are reported as tables. Membership and utilization measures relate to all members. Generally, quality of care measures apply to members continuously enrolled for 12 months with a maximum lapse in coverage of 30 days. Access to care measurements relate to the availability of services. Most general plan management measures require health plans to describe specific services.

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What measures are the QUEST plans required to report?

The QUEST medical plans are required to report measures related to membership, utilization, quality of care, access to care, and general plan management. Since all QUEST plans are required to submit financial statements, and an annual customer satisfaction survey is performed by the Med-QUEST Division (MQD), plans are not required to report financial performance and satisfaction with care as part of their *Medicaid HEDIS* report.

Why is the DHS requiring QUEST plans to report Medicaid HEDIS data?

Medicaid HEDIS has standardized data collecting and reporting requirements and its measures are clearly defined. It allows the evaluation of a plan's performance over time, identification of areas which should be improved, quantitative measurement of strategies a plan uses to improve outcomes, and comparison of similar elements across plans.

What should be considered in reviewing the QUEST Medicaid HEDIS report?

The data presented is an aggregate of data submitted by individual QUEST medical plans. Since *Medicaid HEDIS* specifications allow for data collection using various specified methodologies, the QUEST plans may select alternative methodologies to report the same measure. Therefore, differences in data sources and data collecting methodologies may affect the validity of the aggregate data presented. Additionally, while the QUEST plans reviewed their individual reports and verified the data prior to submission, the Department does not audit each plan's data (NCQA does not require it either). However, the Department executes a protocol to examine the contents for accuracy and consistency.

Medicaid HEDIS specifications require 12 continuous months of enrollment with one lapse in coverage not to exceed 30 days for most of the quality of care measures. Therefore, the quality of care measures do not reflect the experience of a plan's total membership, only that of members who met the definition of "continuously enrolled."

Medicaid HEDIS cautions that data from health plans with "small numbers" for a measure may be of questionable statistical validity.

What are the Medicaid HEDIS measures being reported?

The QUEST plans reported a total of 37 mandatory measures. The collection of these measures is available from the Med-QUEST Division. This report will focus on the following twelve (12)

measures which are key to assessing QUEST's performance in providing quality care:

- Membership by Age and Sex;
- Childhood Immunization;
- Cervical Cancer Screening;
- Cesarean Section;
- Diabetic Retinal Exam;
- Inpatient Acute Hospital Care;
- Emergency Room Visits;
- Live Births;
- Mental Health and Chemical Dependency Services;
- Outpatient Drug Utilization;
- Low Birthweight; and
- Care Access: Utilization of Primary Care Providers by Children.

In addition, a description of how managed care is being provided by the QUEST medical plans is presented. The description includes four key programs in the delivery of managed care services:

- Case Management;
- Utilization Management;
- New Member Orientation/Education; and
- Standards for Waiting Times.

Overall, this report focuses primarily on data submitted by QUEST medical plans for fiscal 1997. However, *Medicaid HEDIS* data for fiscal 1996 is included, when available, to note changes in QUEST performance over time. HEDIS measures were reported in fiscal 1995 but have been excluded for comparison in most instances due to the following reasons:

- QUEST began on August 1, 1994. Therefore, fiscal 1995 for QUEST was only 11 months in duration;
- In the initial months of QUEST, there were many plan changes and significant confusion among providers as to which plan should be receiving and reporting a patient's encounter data;
- *Medicaid HEDIS* measures were not available. Hence, the plans reported a combination of *HEDIS 2.0/2.5* and specific state measures, which in many cases, were not directly comparable with *Medicaid HEDIS* measures.

Membership by Age and Sex

Why is this important?

This measure answers general questions about the people who are receiving their health care services through QUEST.

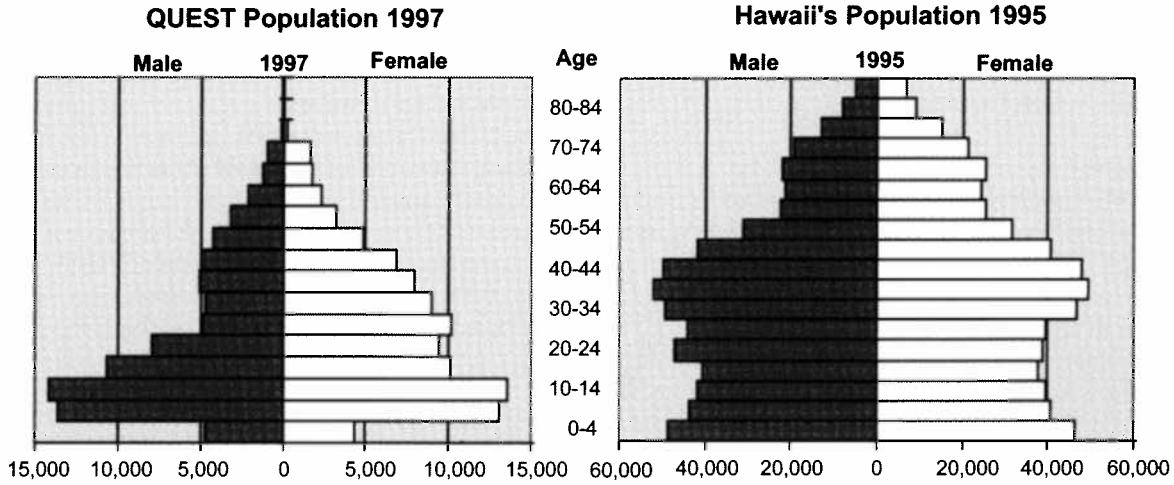
What was measured?

The total number of unduplicated QUEST enrollees by age and sex, enrolled during any part of the report year from July 1, 1996 to June 30, 1997 was recorded.

How did QUEST perform?

Enrollment in QUEST decreased from an average monthly membership of 155,420 in fiscal 1996 to 134,830 in fiscal 1997. The QUEST population in fiscal 1997 was also younger. The mean age of QUEST members dropped to 20.1 years in fiscal 1997 from 21.3 years in fiscal 1996. QUEST members remain predominantly children and adult females. Approximately 56 percent of total membership were children under 20 years of age.

Chart 1



Source: Med-QUEST and DBEDT.

The age and sex distribution of a population for a given fiscal year can be summarized graphically by a "population pyramid." A population pyramid displays the distribution of male and female members in different age-groups. Chart 1 shows QUEST's population structure in fiscal 1997, as compared to Hawaii's resident population in 1995. The QUEST population displays a skewed, classic "pyramid", with a large proportion of younger people, fewer middle-aged people, and far fewer elderly people. There is also a disproportionate number of middle-aged women.

In contrast, the Hawaii resident population structure resembled a bulging "pillar." This is a more mature population, with proportionately fewer young people (ages 0-24) contributing to the total. The middle-aged group (ages 25-54) is the dominant segment of this population structure while the near-elderly (ages 55-64) and elderly (ages 65 and over) appear rather significant before tapering off. The average age of Hawaii's resident population in 1995 was 34.5 years of age. Additionally, there were 102 males per 100 females in the same population. In comparison, there were only 95.6 males per 100 females in the QUEST population in fiscal 1997.

Childhood Immunization

Why is this important?

Immunization in the first two years of life is accepted as one of the most effective public health measures in preventing serious illnesses such as whooping cough, polio, measles, and hepatitis B. Unfortunately, studies have shown that low-income children are less likely to receive timely and adequate immunizations. In 1990, the Centers for Disease Control (CDC) reported that less than 50% of low-income inner city children were fully immunized by age two.

What was measured?

The childhood immunization rate is the percentage of QUEST two-year olds who were enrolled in one plan for 12 months, and who had received appropriate immunizations by their second birthdays (A break in enrollment not to exceed 30 days was allowed).

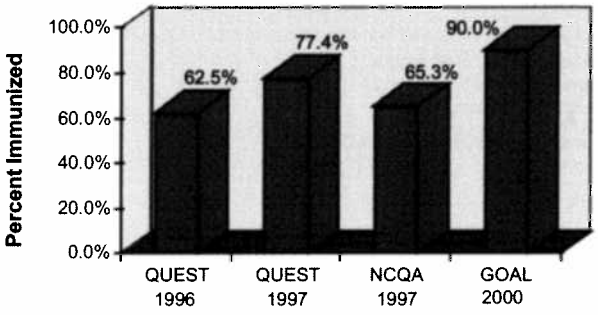
How did QUEST perform?

QUEST did very well compared to the previous fiscal year and to rates reported in other studies. The Childhood Immunization Rate improved to 77.4 percent in fiscal 1997 from 62.5% in fiscal 1996. At this rate of improvement, QUEST should realize the "Healthy People 2000" goal of 90 percent Childhood Immunization Rate.

Recently, the NCQA released its first annual report on HEDIS measures, "The State of Managed Care Quality." This report collected information, voluntarily submitted by over 330 health plans throughout the United States, which participated in the NCQA's accreditation program. The NCQA reported that the national average rate of children who had received 4 DTP/DTaP (diptheria-tetanus-pertussis), 3 polio (OPV/IPV), 1 MMR (measles-mumps-rubella), 1 Hib (H influenza type b), and 2 HepB (Hepatitis B) was 65.3% for the health plans which submitted data. Retrospective studies done in Hawaii on children entering kindergarten have shown that between 58-63% received the basic series by age 2.

Chart 2

Childhood Immunization Rates



Source: Med-QUEST and NCQA.

Cervical Cancer Screening

Why is this important?

Nationally, more than 13,000 new cases of cervical cancer are diagnosed each year, and 4,800 women die of the disease annually.

Additionally, the rate of cervical cancer is typically higher among poor women and they are more likely to be diagnosed when the cancer is in advanced stages. Fortunately, cervical cancer is curable if detected early by regular check-ups and the use of the Papanicolaou (Pap) smear test. Thus, for Medicaid women, cervical cancer screening is very important and saves lives.

What was measured?

The cervical cancer screening rate is the percentage of women aged 16 to 64, enrolled in a medical plan for 12 months, who had at least one Pap smear during the past three years.

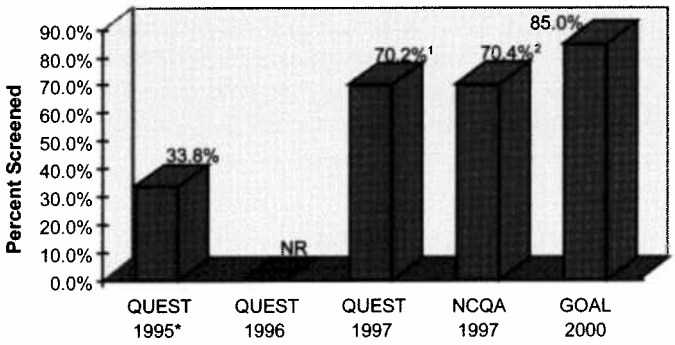
How did QUEST perform?

The QUEST medical plans did not report this measure in fiscal 1996. In fiscal 1995, the reported rate was 33.8 percent. This rate was for the first eleven (11) months of QUEST program and was reported by four (4) of the five (5) plans. Another shortcoming of the 1995 QUEST data was the plans did not have three years worth of data as required by the measure.

In fiscal 1997, the QUEST screening rate reported was 70.2 percent (women aged 16 to 64). This screening rate is compatible with a recently released NCQA study which reported a 70.4 percent national average for women aged 21 to 64 in participating health plans. The "Healthy People 2000" goal is to have 85 percent of all women receive a Pap smear every one to three years.

Chart 3

Cervical Cancer Screening Rates



*Rate for 11 months and reported by 4 out of 5 QUEST plans.
[1]Women aged 16-64 years.
[2]Women aged 21-64 years.
NR: Not Reported.

Source: Med-QUEST and NCQA.

Cesarean Section

Why is this important?

Cesarean (C)-sections are among the most frequent surgical procedures performed in the United States and both mother and neonate have a greater chance of complications than with vaginal birth. A C-section is normally unnecessary if vaginal delivery of the baby does not pose a serious health risk to the infant or mother. Hospital and physician services associated with C-section deliveries are more costly than vaginal deliveries. Therefore, the rate of C-section deliveries is an indicator of appropriate clinical management and quality of care.

What was measured?

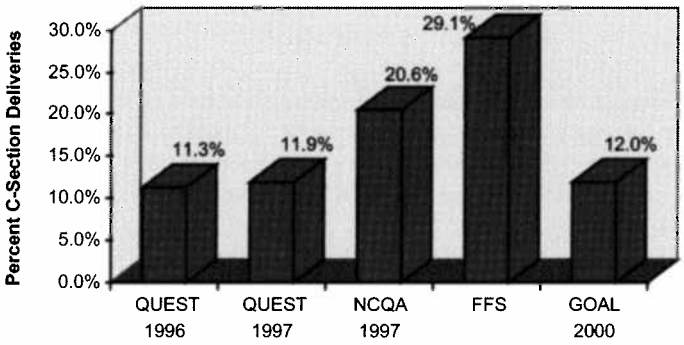
The C-section rate is the percentage of total QUEST deliveries resulting in live newborns which were C-section delivered in fiscal 1997.

How did QUEST perform?

The QUEST plans performed very well in this measure. In fiscal 1996 and fiscal 1997, the QUEST C-section rates were essentially unchanged at about 11 percent (see Chart 4). This rate is far lower than the NCQA's national average of 20.6 percent, and the national fee-for-service (FFS) rate of 29.1 percent. QUEST's fiscal 1996 and fiscal 1997 rates have actually exceeded the national health's established C-section rate of 12-15 percent by the year 2000.

Chart 4

Cesarean Section Rates



Source: Med-QUEST and NCQA.

Diabetic Retinal Exam

Why is this important?

Diabetes mellitus affects about 6.5 percent of Hawaii's population, and it is the leading cause of severe eye damage and adult blindness in the United States. However, blindness can be prevented if retinal changes are detected early, and treated appropriately with laser. Therefore, early intervention through effective screening is crucial in preserving the eye sight of individuals with diabetes.

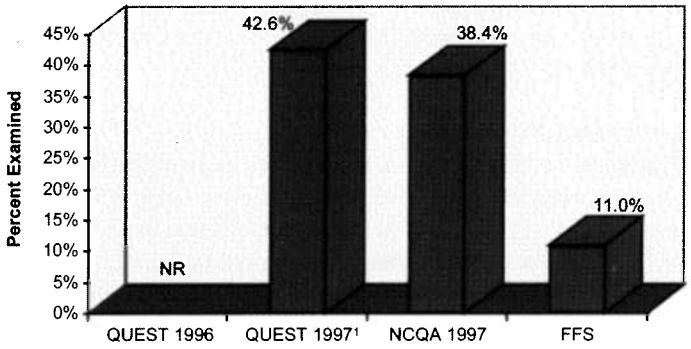
What was measured?

This was an optional measure for QUEST plans. However, two of the larger medical plans submitted data on this measure for fiscal 1997. The diabetic eye exam rate is the percentage of plan members with diabetes aged 31 to 64 years who received an ophthalmoscopic eye exam in fiscal 1997. Members in the plan must be enrolled continuously during the reporting period (allowing for one break in service, not to exceed 30 days).

How did QUEST perform?

In this measure, QUEST out-performed both the NCQA's national average and FFS rates (see Chart 5). The QUEST rate of 42.6 percent in fiscal 1997 indicates that the QUEST performance compares favorably with that of managed care in the private sector. QUEST plans did not report this measure in fiscal 1996.

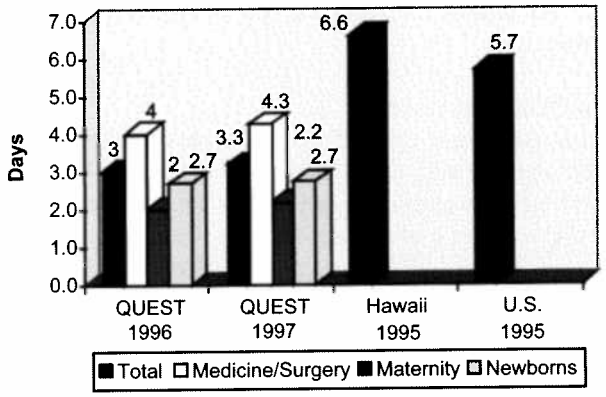
Chart 5
Diabetic Retinal Exam



¹Optional Measure: Two primary plans reporting.
NR: Not Reported.

Source: Med-QUEST and NCQA.

Chart 6
Inpatient Average Length of Stay



Source: Med-QUEST.

Inpatient Acute Hospital Care

Why is this important?

Inpatient acute hospital care is one of the most costly expenses of a health plan. It is a measure of a plan's performance in managing patient care.

What was measured?

The total number of QUEST enrollees who received inpatient hospital care and the category of care they received (medical/surgical; maternity; and newborns) by age were measured. The total number of hospital days, days by category of care, and the average length of stay (ALOS) were also reported.

How did QUEST perform?

Compared with the previous fiscal year, there were fewer total days and fewer inpatient discharges. This was consistent with the decrease in enrollment. However, the total ALOS and the ALOS for each category of care remained essentially the same (see Chart 6). The QUEST ALOS for total acute inpatients was 3.3 days in fiscal 1997. In contrast, the latest available statewide and national ALOS reported by the Healthcare Association of Hawaii for acute care hospitals in 1995 were 6.5 days and 5.7 days respectively.

Emergency Room Visits

Why is this important?

The emergency room rate is a critical measure of appropriate utilization of health care because a visit to the emergency room is largely member initiated, and emergency room costs for non-emergency care are much higher than visits to PCPs. Historically, the higher emergency room utilization of Medicaid populations compared with the general public has been attributed to the inadequate access by Medicaid enrollees to other primary care options. By providing education to patients so that they will utilize emergency room services more appropriately and by improving access to primary care, managed care plans should be able to bring down emergency room rates.

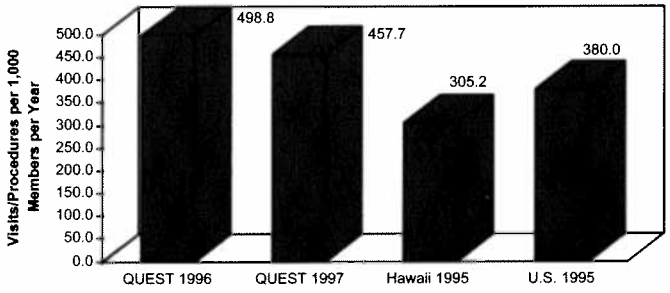
What was measured?

This HEDIS measurement reports the total number of QUEST emergency room visits which did not result in inpatient stays. Each visit is counted once, regardless of the intensity of care required or the length of time spent.

How did QUEST perform?

Compared with the previous fiscal year, QUEST showed improvement. The total number of emergency room visits and the rate of emergency room utilization had both decreased. In fiscal 1997, the QUEST emergency room rate was 457.7 per 1,000 members. This rate is higher than the last available 1995 rates of 305.2 per 1,000 population statewide and the national rate of 380 per 1,000 population. We believe the emergency room rate for QUEST will decrease further in future as QUEST members become better educated on appropriate use of emergency room services and how to better access services through PCPs.

Chart 7
Emergency Room Visits



Source: Med-QUEST and AARP.

Live Births

Why is this important?

Medicaid has traditionally been a major payer for deliveries and newborn care. In the late 1980s, the federal government encouraged states to expand income eligibility for pregnant women and newborns because of studies which demonstrated savings of at least $3 in direct care for each dollar spent on care given to pregnant women. Thus, this HEDIS measure is important because it enumerates the deliveries covered by QUEST and the general health of the newborns after delivery.

What was measured?

The total number of live births (including separate counts of well newborns and complex newborns), the number of inpatient hospital days, and the average length of stay for women of different ages were reported.

How did QUEST perform?

The total number of QUEST deliveries resulting in live births decreased from 4,916 in fiscal 1996 to 4,065 in fiscal 1997. However, the average length of hospital stays for well newborns increased slightly from 1.44 days to 1.74 days, while that for complex cases decreased from 16.46 days to 15.46 days. We feel that the decrease in births can be explained by the decrease in QUEST enrollment. The increase in average length of stay for well newborns is consistent with the QUEST policy of allowing physicians and families to determine how long a healthy newborn and mother should remain in hospital.

Mental Health and Chemical Dependency Services

Why is this important?

Utilization of mental health and chemical dependency services is important because it is an indirect measure of a QUEST member's ability to access these services. Beyond that, it measures the adequacy of the provider network established by a QUEST plan to provide appropriate mental health and chemical dependency services.

What was measured?

The utilization of mental health/chemical dependency services by age and sex was measured. The services are grouped into the following general categories—(1) members receiving any service; (2) inpatient hospital services; (3) day/night services, and (4) ambulatory services.

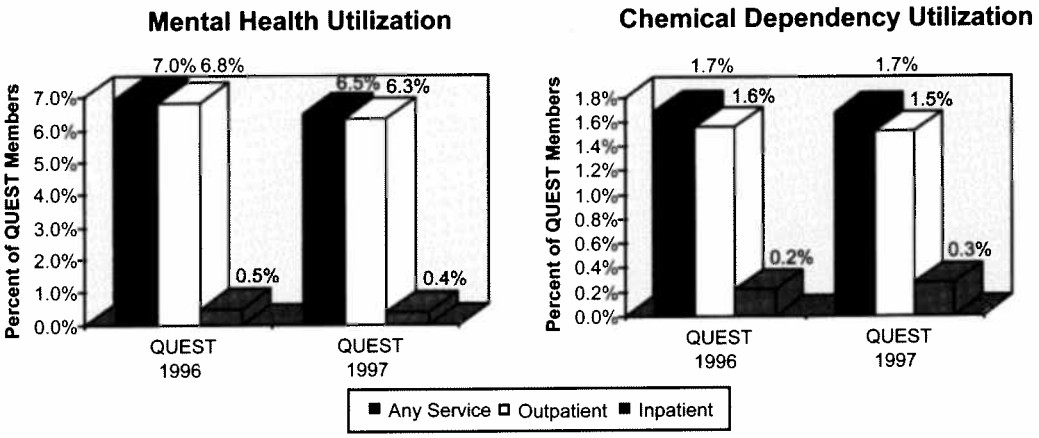
How did QUEST perform?

The actual number of mental health services provided decreased 9.6 percent between fiscal 1996 and fiscal 1997. Chart 8 shows the decrease was less significant as a percentage of members receiving services across the different categories of services. This is consistent with the decrease in overall QUEST enrollment count of six (6) percent. For chemical dependency services, the actual number of services dropped four (4) percent but the percentage of members who had received these services by different categories remained essentially unchanged.

In addition to the decrease in QUEST membership, the following factors should be considered in evaluating the decline in actual number of mental health and chemical dependency services:

- The benefit package for mental health and chemical dependency services was unlimited for the first eight (8) months of fiscal 1996 but limited to 30 inpatient hospital days and 24 hours of outpatient services in fiscal 1997;
- One QUEST plan reported encounters for 11 months instead of 12 months for fiscal 1997, thus the actual number of services provided should be higher;

Chart 8



Source: Med-QUEST.

- The processing of enrollment into the behavioral managed care plan for the seriously mentally ill (SMI) adults improved. Therefore, mental health services used by QUEST members in most need of mental health services were not being provided and reported by the QUEST plans. Instead, these services were being provided by the QUEST behavioral managed care plan for SMI adults.

Outpatient Drug Utilization

Why is this important?

This measure assists health plans and the Department to assess how cost effective the QUEST drug benefit is being administered.

What is being measured?

The total cost of prescription drugs, the average cost per member per month, the total number of prescriptions filled, and the average number of prescriptions filled per year for QUEST members of different ages are measured.

How did QUEST perform?

The total costs of QUEST drug benefits decreased by more than $6 million in fiscal 1997 compared with fiscal 1996. Cost per member per month decreased by 13.6 percent from $13.92 to $12.03. The total number and average number of prescriptions filled also decreased. Studies have shown that decreases in drug benefits, if done inappropriately, may be accompanied by increases in emergency room visits, mental health services, and inpatient hospital utilization. This did not happen in the QUEST program and thus, we feel the decreases in the drug benefit did not affect access to care, nor did it promote overutilization of more costly care. The inference is that the imposition of managed care provided needed control on drug utilization without denying access.

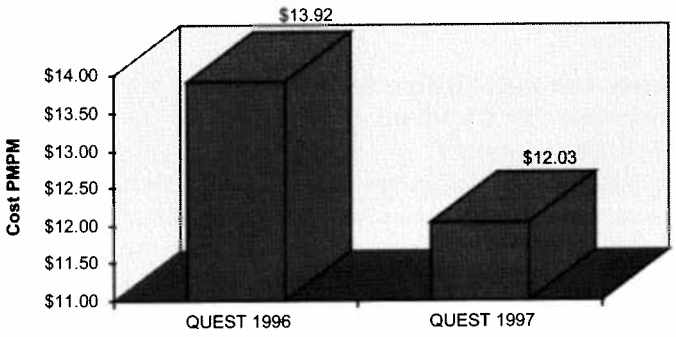
Low Birthweight

Why is this important?

In the United States, 263,000 low birthweight infants (weight less than 2,500 grams) are born annually. Low birthweight infants face higher risk for chronic and permanent disabilities, serious medical complications and illnesses, and death in infancy. Low-income women are typically at higher risk for having low birthweight infants. There are many factors which increase a woman's risk of having a low birthweight infant. Some of the more common factors include smoking, poor nutrition, and chronic medical conditions. It is widely felt by the medical profession that the incidence of low birthweight can be decreased by improving access to appropriate prenatal care.

Chart 9

Outpatient Drug Utilization



Source: Med-QUEST.

What was measured?

The percentage of low birthweight (less than 2,500 grams) infants born during the fiscal year was measured using hospital discharge data or birth certificate data.

How did QUEST perform?

Although the number of low birthweight babies crept up slightly from fiscal 1996 to fiscal 1997, the QUEST rate is still very good and do not indicate that QUEST pregnant women have a higher rate of low birthweight infants compared to their peers in the state. Chart 10 shows that QUEST's low birthweight rate of 5.8 percent in fiscal 1997 is lower than the overall state's rate of 6.7 percent in 1996. We

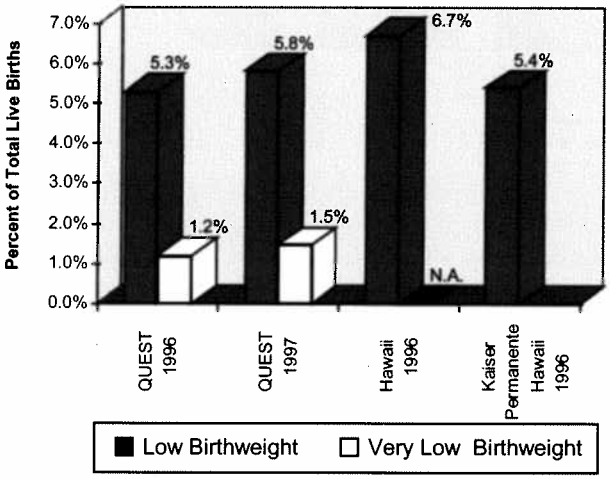
believe QUEST is doing well in this measure and will continue to do so in the future with better monitoring and pre-natal care for members.

The QUEST low birthweight rate of 5.3% in fiscal 1996 was actually better than Kaiser Permanente Hawaii's commercial plan rate of 5.4 percent[1] in calendar year 1996.

Kaiser Permanente Hawaii is ranked as one of the best managed care plans in the United States.

Chart 10

Low Birthweight Babies



Source: Med-QUEST & DOH.

Care Access: Utilization of Primary Care Providers by Children

Why is this important?

Traditionally, under the fee-for-service Medicaid Program, access to non-emergency care was difficult to obtain. One of the primary reasons Hawaii turned to managed care was to improve access to non-urgent, preventive care. By requiring that each QUEST member have his/her own primary care provider (PCP), the State felt that access to medical care and the general health of Medicaid recipients would be improved. Children comprise about 56 percent of total QUEST membership. Therefore, children's utilization of primary care services through PCPs is an important measure of access.

What was measured?

The rates of utilization of primary care providers by children are the rates of QUEST children enrolled in one plan for 12 months by the following age categories:

- children aged 12 to 24 months who had at least one visit to a primary care provider (PCP) during the past 12 months;
- children 25 months to 6 years who had at least one visit to a primary care provider (PCP) during the past 12 months; and
- children aged 7 years to 11 years, enrolled in one plan for two years, who had at least one visit to a PCP in the past 12 to 24 months.

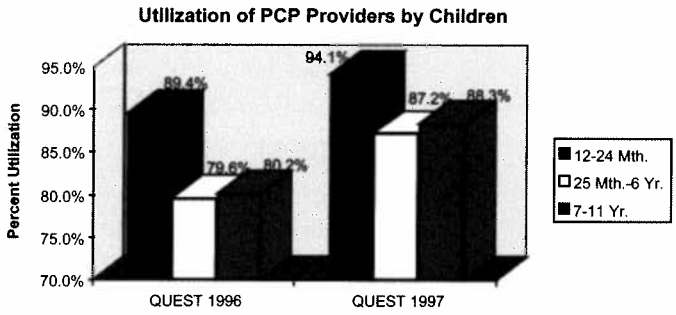
[1]See Kaiser Permanente Hawaii's 1997 Quality Report (page 11). Kaiser Permanente Hawaii recently received a four-star rating, and was ranked as the sixth best plan in the U.S. News & World Report's annual appraisal of "America s Top HMOs."

How did QUEST perform?

In fiscal 1997, the utilization of PCPs by QUEST children continued to improve. In fiscal 1996, QUEST's rates for the different age categories exceeded 80 percent. The average utilization rate for all three age categories was about 83 percent (see Chart 11). In fiscal 1997, rates for the different age categories jumped to the high 80s and the average utilization for all three age groups jumped to 90 percent. The inference here is that QUEST children have excellent access to their PCPs.

Chart 11

Utilization of PCP Providers by Children



Source: Med-QUEST.

Managed Care in Hawaii QUEST

In fiscal 1997, QUEST eligible persons were able to choose from five (5) QUEST medical plans. These QUEST plans are unique with five (5) different approaches to the delivery of medical care and five (5) different structures and organizational experiences. A summary description of the QUEST medical plans is as follows:

- **AlohaCare** is a plan formed by community health centers, and QUEST is its single line of business;
- **HMSA-QUEST** is a plan by a local, non-profit, mutual benefit society associated with Blue Cross/Blue Shield — with many commercial lines of business;
- **Kaiser Permanente QUEST** is a plan by a large, nationally affiliated, non-profit Health Maintenance Organization (HMO);
- **Queen's Hawaii Care** is a plan by a local, non-profit health care system; and
- **Straub Care Quantum** is a plan by a local, for-profit health care system.

Kaiser Permanente QUEST and **Straub Care Quantum** can be described as "closed panel" health plans because the care they provide is largely performed by their staff physicians in their own clinics and facilities. **AlohaCare, HMSA-QUEST,** and **Queen's Hawaii Care** are "open panel" health plans which contract with health care providers to provide care at various sites, largely, the providers' offices and facilities.

Although each QUEST health plan operates differently, all of the plans utilize managed care concepts in the provision of health care to QUEST members. Four (4) key components which are critical to the delivery of care in managed care and how these programs are used by QUEST health plans will be briefly described.

Case Management

What is it?

Case Management is a process to identify and assist members with complex or chronic conditions. This includes helping members who have difficulties in obtaining needed medical care to gain access and to obtain the appropriate care.

How do QUEST plans perform case management?

All of the plans have systems which identify members who may need case management/care coordination. Although plans are free to determine which recipients need case management, generally, plans priorities for case management are similar, and include high risk pregnancies, lengthy hospitalizations, and chronic diseases such as asthma or diabetes.

The two closed panel plans perform case management services using plan staff. The three open panel plans also perform most case management activities using plan staff. In addition, **AlohaCare** uses case management services of the community health centers. **HMSA-QUEST** contracts with the community health centers and other community agencies for specific outreach services such as transportation, translation and non-compliance counseling. **Queen's Hawaii Care** has contracted for patient education and case management to assist providers on a neighbor island in an Asthma Management Program.

Utilization Management

What is it?

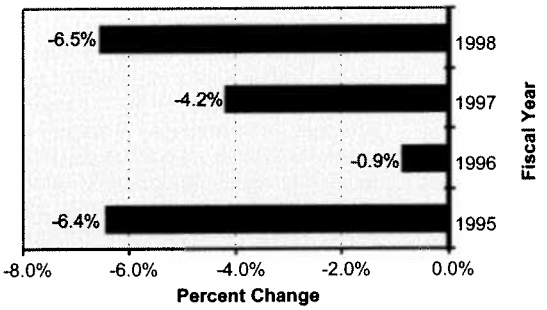
Utilization management is the process which plans use to determine the appropriateness and need for medical care. Plans evaluate utilization patterns (including under-utilization and over-utilization) through data analysis and provider profiling. Among the specific programs used to make decisions of appropriateness and need are prior authorization, concurrent review, and retrospective review.

How do QUEST plans perform utilization management?

Although plans differ in the specific services/situations which require prior authorization, all plans utilize prior authorization in some form. For inpatient hospital, concurrent and retrospective reviews, all five (5) plans employ national standard criteria such as InterQual Severity of Illness/Intensity of Service, Milliman and Robertson's Length of Stay Guidelines and/or Medical Care Appropriateness Protocol (MCAP) as part of their utilization review protocols.

Chart 12

Change in Per Capita QUEST Cost*



*TANF and GA Categories Only. Costs include projected costs for adult dental care after February 1996.

Source: Med-QUEST.

New Member Orientation/Education

What is it?

New member orientation/education are the activities performed by plans to educate and orient new members on the types of covered services and how to access those care services.

How do QUEST plans do this?

All QUEST plans send welcome packets of information including a member handbook, list of providers, summary of plan benefits, how a member can access care, and member rights and responsibilities. In addition, **HMSA-QUEST** conducts optional member orientation sessions; **Kaiser Permanente QUEST** has case management assistants and visiting nurses who work directly with new enrollees; **Straub Care Quantum** includes in its welcome packet the (800) number of its HMO Services personnel who can answer questions and assist members in obtaining services; **Queen's Hawaii Care** issues quarterly member newsletters which features educational material as well as updated plan member services; **AlohaCare** uses its Member Services department to reinforce the programs in the Member Handbook. Also, all plans send out Early and Periodic Screening, Diagnosis and Treatment (EPSDT) information. (Under Federal EPSDT rules children are entitled to a broader range of Medicaid services than adults and it is required that parents receive information explaining EPSDT benefits).

Standards for Waiting Times

What are these?

Each plan sets its own standards for acceptable waiting times for the following:

1. **Emergency care**;
2. **Urgent routine illness**; and
3. **Preventive and non-urgent routine care**.

What are the standards used by the plans and how are they being monitored?

Although each plan sets its own standards for waiting times, all plans are generally in agreement that the standard waiting time are as follows:

1. **Emergency care** is immediately (within the same day);
2. **Urgent routine illness** is from 24 to 48 hours; and
3. **Preventive and non-urgent routine care** is from 24-48 hours to 6 weeks.

Plans monitor these standards by on-site visits to providers (**Queen's Hawaii Care and HMSA-QUEST**), member surveys and appointment accessibility surveys (**HMSA-QUEST**), waiting time surveys (**Straub Care Quantum**), actual measurements (**Kaiser Permanente QUEST**), and member education on appropriate use of services (**AlohaCare**).

Quest Capitation History

When QUEST was initiated in August 1994, the premium savings associated with each enrolled member was approximately 6.4 percent lower than payments under the previous fee-for-service system. Chart 12 shows that more premium savings have been realized subsequently in fiscal 1996, fiscal 1997 and fiscal 1998, without compromising quality health care services to the QUEST population. Selected clinical measures reported under HEDIS guidelines have supported this contention. We believe much of the success is attributable to productivity gains and continuous quality improvements in both clinical and administrative areas of participating QUEST plans.

Towards the Millenium

The member's freedom to choose a health plan has always been an important consideration in QUEST. As participating QUEST plans continue to mature in utilizing managed care concepts in the provision of services to the Medicaid population, they are continuously driven to improving and upgrading their services. The plans are fully aware of their similar product offerings, and that quality of service is the key determinant to winning consumer confidence. QUEST members are the primary beneficiaries of this competitive structure established by the State. The DHS, through its Med-QUEST Division will continue in its efforts to monitor the quality of services offered by participating plans. The MQD is also exploring innovative ways to improve the delivery of health care services to the Medicaid population in Hawaii, currently not in QUEST.

As we move closer to the millennium, QUEST is working diligently to extend managed care services to more Medicaid recipients. We believe that managed care can effectively deliver to the Medicaid population, greater access to non-urgent and preventive health care services, and improvement in their general health status. The offering of long-term care services through a managed care setting is currently under consideration. Certain segments of Hawaii's community view this as a viable, "high-value" alternative to the existing fee-for-service system. With each existing, and potential service offering, consumer protection will continue to remain a key pillar of QUEST's efforts. And towards achieving this goal, QUEST will continue to use HEDIS measures to define quality of care services in a tangible, quantitative, and meaningful manner.